APPENDIX J

Page _____ of _____[1]

INDEPENDENT PROVIDER MILEAGE REIMBURSEMENT CLAIM FORM

TRIBE :_____

Provider Name/AHCCCS ID Number:	**Month & Year:**[2]
Driver License Number:	**Car License Number:**

Date[3]	**Member Name, AHCCCS ID, and Address/Location**[4]	**Odometer**		**Total Miles**	**Minus 25 Miles**	**Reimbursable Miles**[5]
		Start	**End**			
					-25	
					-25	
					-25	
					-25	
					-25	
					Total Reimbursable Miles:	

Number of Reimbursable Miles X State reimbursement rate per mile = $ Reimbursement

[1] Use as many pages as necessary to record the entire activity for one month. On each page in this area enter the page number and the total number of pages needed to complete the form, for example, Page 1 of 5, Page 2 of 5, etc.

[2] Only use one form per month, for example, use one form for January and a different form for February.

[3] Use a new line to record the entire activity for each new date.

[4] Indicate the **NAME**, **AHCCCS ID** and **ADDRESS** of **EACH** member served on that date.

[5] For each date AHCCCS will pay mileage to provider after the provider has traveled 25 miles. Multiple days cannot be added together to reach a total of 25 miles. Mileage for each date is only reimbursed when the provider has traveled over 25 miles to and from **ALTCS** Fee-for-Service Members' homes.